Society Proceedings

AMERICAN NEUROLOGICAL ASSOCIATION.

Thirty-Second Annual Meeting, Held at Boston, June 4 and 5, 1906,

The President, Dr. Henry R. Stedman, in the Chair.

(*Continued from page* 670.)

The Limitation of Hysteria.—By Dr. Charles L. Dana. Dr. Dana, in his paper, argued that the term "hysteria," as indicating a special disease, should be limited only to those severe forms of hysteria which are associated with permanent and definite physical and mental stigmata. He also argued that many of these cases, especially the severe types, were really teratological defects, rather than simply "doubting of personality." In these cases certain associative functions had become worn out and were degenerated and incurable, like forms of torticollis or "occupation" neuroses. He tried to depict a special form of psychoneurosis, to which he would give the name of *psychasthenia.* It was a peculiar mental condition, usually called "hysteria," and sometimes called "hypochondria" and "neurasthenia." He thought it was a special form of minor psychosis, and had best be separated from true hysteria as well as from neurasthenia. He thought that it also was somewhat different from the well-marked types of obsession, characterized by doubting mania and morbid fears. The psychoneuroses, therefore, would be grouped under the following classes:

I. The true hysteria.

II. Psychasthenia of the hypochondriacal type, and psychasthenia with obsessions and fears, for all which he gave the general name of *phrenasthenia.*

III. Neurasthenia.

IV. The abortive forms of the major psychoses, such as melancholia, paresis and so forth.

He had been accustomed to use the term *phrenasthenia* to include both forms of psychasthenia; that is, both the hypochondriacal and that type which was characterized by doubting mania and violent types of fears and obsessions.

Dr. Dercum said that the various forms of nervousness resolve themselves into cases presenting well marked symptoms of the fatigue neurosis, neurasthenia, others with well marked stigmata of hysteria, and others still in which the patient presents the symptoms of a confirmed belief in general or visceral disease. Among the latter we frequently find patients who have passed through the hands of a surgeon for various operations; operation for the fixation of a displaced kidney or for affections, real or supposed, of the pelvic organs. Such patients, as is well known, return time and again to the physician for renewed surgical interference. These cases, it is perfectly true, are not cases of hysteria, but should unquestionably be classed under hypochondria. There is another group of cases which resemble neurasthenia, but in which the typical symptoms of over-fatigue are not present, and in which the nervous condition is symptomatic of some general or local disorder which is prodromal to some more serious nervous disease. These cases, for want of a better name, Dr. Dercum had termed neurasthenoid.

Dr. Deady said he liked to be practical about hysteria, and he thought we should try to get rid of all these different conceptions and groups of types of hysteria. There are certain psychological cases, people of highly imaginative temperaments who always get sick along hysterical lines. There is a type of hysteric who is a perfectly normal person, and when he gets sick his illness is of the hysterical type. Dr. Deady meant functionally, in the sense that whatever happens to that individual he has functional conditions. That person may be neurasthenic or psychasthenic, or anything you wish to call it, but the thing which underlies it all is the subconscious condition. Dr. Prince speaks of curing hysteria. Dr. Deady thought there is no cure for hysteria. We can, however, cure hysteric symptoms. In short, the hysteric is a biological type, born that way, and almost of necessity he is hysterical, and he may do those things and be perfectly normal. For instance, a somnambulist is hysteric, but is normal, and remains that way all his life. If you try any of the methods by which we bring out automatism, he will show the stigmata. The true hysterical cases are always subconscious. In those cases to which Dr. Dana refers, those who rush to bed when there is the slightest trouble, Dr. Deady believed there is a mental lack of reality, a lack of concreteness. The woman who runs to the doctor with the slightest pain is the one that is afraid to cross the street. The hysteric is a normal person who will never get sick except in a hysterical way.

Another point. Alcohol has nothing whatsoever to do with producing hysteria. Hysteria is a distinct variety, and if the parents are alcoholics before the child is born the child may be a degenerate biologically, but he is not necessarily hysteric, and his parents are not degenerate because they are alcoholic.

Dr. Dana said he was much obliged to the gentlemen for their criticism of his paper. He could see that those who differed from him did so because they looked at the question from a different point of view.

He would divide the so-called psychoneuroses into these groups:

I. Neurasthenia.

II. Abortive types of the major psychoses; *e. g.*, melancholia, manic-depressive psychoses.

III. Phrenasthenia, including:

a. Hysteria major.

b. Psychasthenia hypochondriacal.

c. Psychasthenia obsessive.

It is the type III. *b.* or hypochondriacal psychasthenia, sometimes called hypochondriasis, or hystero-neurasthenia, or hysteria, which he would seaparate as a special group. The obsessive types, such as mysophobia, sometimes develop into a real major psychosis. Hysterical episodes occur in all the groups.

The Pupil in Tabes, Paresis and Syphilis.—By Dr. F. X. Dercum. A brief analysis of the symptoms presented by the pupil in each of the above forms, and especially a consideration of the points of differential value.

Dr. William M. Leszynsky said that the Argyll-Robertson pupil was originally described as myosis associated with loss of reaction to light. It is only when the cervical cord is involved in the tabetic degeneration that we find myosis, and the latter is always accompanied by loss of the pupillary light reflex. The same may be said of the tabetic type of general paresis. In the other forms of tabes and in uncomplicated general paresis, while myosis is absent, the pupils may fail to react to light. We cannot safely lay any stress on the presence of inequality of the pupils alone, without a careful preliminary study of the refraction and the condition of the media.

The teachings of Hutchinson as to the syphilitic basis of abnormal pupillary conditions without intraocular changes, still holds good in a large majority of cases. Unilateral loss of the pupillary light reflex may occur in any of the affections mentioned, as is well-known. In a case of cerebrospinal syphilis under Dr. Leszynsky's observation this unilateral symptom existed for several years before the other eye became similarly affected. It is not usually recognized that unilateral loss of the light reflex may be a residual condition following a third nerve paralysis. Several such cases have been reported in the *Transactions of the British Ophthalmological Society.*

Dr. W. C. Krauss said he had lately made an examination of the eyes of the patients in the Buffalo State Hospital for the Insane with respect to the pupils, and the early appearance of irregularities of the pupils in paresis. In half of the cases examined there existed anomalies in the size of the pupils and in half of these cases there existed the Argyll-Robertson pupil. The appearance of irregular pupils in so-called cases of neurasthenia is of the utmost importance, and as a rule presages an oncoming paresis. When present it is a very important prognostic symptom, and promise of recovery should not be too hastily given.

Dr. Joseph Collins said it seemed to him that one point which deserves discussion is the importance of the inequality of the pupils in patients who have not had syphilis. Is inequality of the pupils in and of itself a sign of any importance, or does it indicate that its possessor is in greater jeopardy of developing paralysis or tabes than one whose pupils are normal? This is a subject upon which we are sadly in need of illumination.

Dr. Knapp thought we are in need of more definite data in regard to the Argyll-Robertson pupil, whether it may occur in persons who are not syphilitic or in persons who are not going to develop paresis or tabes. He confessed that he always looked upon it with grave suspicion, but the data upon this point are still unsatisfactory. If a patient comes before him with this condition he did not think we are justified in saying positively that the patient is syphilitic, or in giving a prognosis that it will probably develop into tabes or paresis.

Dr. H. M. Thomas said that Dr. Dercum's statistics had interested him much, and in one point particularly, where, if he understood correctly, they are somewhat at variance with those given by Professor Mott, of London. Dr. Dercum concluded that optic atrophy is more common in tabes than in paresis, whereas Mott in his monograph on "Tabes in Asylum and Hospital Practice" assumes that in his asylum cases of tabo-paralysis optic atrophy occurred in about 50 per cent. of the cases. The point is an important one as a possible aid to the early differentiation of those cases in which mental symptoms are apt to develop, and Dr. Thomas asked Dr. Dercum if his figures throw any light on this question.

In regard to the pupils in tabes and paresis, there is an action which has not been mentioned, but which is often seen in connection with the Argyll-Robertson pupil, and which at times helps to determine this condition. It is the contraction of the pupil associated with forced action of the orbicularis palpebrarum, and is tested for by directing the patient to close his eye firmly and then to open it, when it will be seen that the pupil has become smaller, and that it gradually dilates in spite of the influence of light. The phenomenon appears to be a normal associated movement which is usually masked by the more active light reflex acting against it, and is, therefore, best seen in a dilated pupil which does not react or which reacts poorly to light.

Dr. Dana said one point in connection with this subject is the great difference in methods of examination. For example, he was talking with an ophthalmologist recently in regard to his method of finding the Argyll-Robertson pupil. He puts the patient in the dark room and throws light upon the pupil. We put our patient into an ordinary room, sometimes in the sunlight, sometimes candle light, sometimes electric light. Dr. Dana suggested some years ago that the ophthalmologist or the neurologist standardize the method. For sometimes it is difficult to say whether there is a pathological pupil or not. He thought if we had a definite uniform method it would make our records more valuable.

Dr. Fisher referred to a case which came under his observation. It was a very slow case of tabes with a markedly dilated pupil. Under antisyphilitic treatment the dilatation of the pupil (not the Argyll-Robertson pupil) entirely disappeared, and as the oculist who examined him said, this rarely occurs in tertiary syphilis.

Dr. Dercum closed the discussion.

The question which Dr. Collins asked, whether we should regard the pupil which does not react to light as always indicative of an oncoming tabes, must, he thought, be answered in the negative. It is true that it is usually indicative of an oncoming or an already existing tabes, but not invariably so. He recalled the case of a young woman, a patient studied repeatedly by Dr. de Schweinitz and himself, in which the left pupil was absolutely immobile to light. In this patient, who had also some of the stigmata of hysteria, the symptom persisted during all the time that she was under observation, a period of several years. However, he thought it was of the utmost importance to regard a pupil which reacts sluggishly to light with great suspicion. He was thoroughly in accord with what Dr. Dana said in regard to the method of making the examination, and where the result is in doubt in his own mind he usually had an independent examination made by one of his ophthalmological friends.

The Cerebral Element in the Reflexes and Its Relation to the Spinal Element. By Dr. George L. Walton and Dr. W. C. Paul. (See this journal, page 681.)

Dr. Knapp said he was not disposed to agree wholly with Dr. Walton in this matter. He thought his rules were certainly too sweeping; as for instance, when he speaks of the complete cutting off of cerebral control causing the abolition of reflexes. For example, Dr. Knapp had seen cases of complete division of the spinal cord where there was loss of the knee-jerk, but with retention of the plantar reflexes, and others with loss of plantar reflexes and knee-jerks. Immediately after a hemiplegic attack there may be an exaggeration of tendon reflexes on the paralyzed side, but sometimes there is a diminution. Occasionally immediately after an epileptic seizure the knee-jerk may be lost, but in other cases it becomes exaggerated to the point of clonus. Therefore, it seemed to him that all these rules are subject to modification.

Dr. Mills said it seemed to him that Dr. Walton and Dr. Paul had not paid sufficient attention to the subject of localization in their consideration of the cerebral reflexes. This appeared to him to be the key to the explanation of the modifications of the reflexes often present. A lesion, such as a tumor or a hemorrhage, involving the cerebral motor zone or the pyramidal tracts, in his experience, almost invariably caused the Babinski response, and increase of the deep reflexes. Parietal tumors and other lesions, whether cortical or subcortical, either caused no change of moment in the reflexes or their diminution. He had several times watched an interesting process of evolution as regards reflex phenomena take place in cases of cerebral tumors. In a case of tumor of the parietal lobe for instance, in which at first the knee jerk was diminished, and a normal plantar reflex was present, but not pronounced, as time went on the knee jerk increased and ankle clonus appeared, while on plantar stimulation no response could be had for a time, and later a Babinski was easily elicited. Evidently this case was one in which a growth at first parietal, encroached later upon the pyramidal tracts and motor cortex. A prefrontal tumor which at first gives no positive reflex disorder may later show the phenomena to be expected in a case of motor region growth.

Dr. B. Sachs said he, like many others, had tried to find a satisfactory explanation of the reflexes. He had felt that particularly in the more chronic cases the presence of sclerotic tissue in the spinal cord acts as an irritant. Cerebral inhibition probably has much to do with it, but it is the presence in the spinal cord of diseased tissue which keeps up the trouble.

Dr. Walton, in closing the discussion, said that the contribution was offered not as completely covering the ground, but as a step in the direction of including in our scheme of reflexes the brain as an integral part working with the cord, instead of an obstructant working in opposition to the cord. He deplored the conservative tendency which prevents our recognizing, or causes us falsely to interpret, the not infrequent loss of reflexes in cerebral disease. He agreed with Pandi that it is illogical to credit the brain and the spinal cord with opposing functions.

Sexual Infantilism, with Optic Atrophy in Cases of Tumor Affecting the Hypophysis Cerebri.—By Dr. Harvey Cushing. (See this journal, p. 704.)

Dr. Spiller said that primary optic atrophy is not uncommon in tumors of the hypophysis cerebri. Arrest of menstruation occasionally occurs in cases of brain tumor. He had had a case during the past year in which menstruation ceased four years ago. Recently menstruation occurred after improvement following a palliative operation on the skull.

Optic neuritis as a sign of cerebral hemorrhage is regarded, and Dr. Spiller thought justly so, as rare. Within the past few weeks, however, Dr. Spiller had had a case in which it occurred. This sign may lead to a diagnosis of tumor instead of hemorrhage if one is not on his guard.

Dr. Dercum said that there is and must be a close relationship between all the internal secretions, and in cases of this kind it would not be strange if there were interference with the function of other ductless glands than the pituitary, for example of the ovaries. It is also suggestive from the standpoint of acromegaly that in these cases there is no sexual power or desire.

Dr. Joseph Collins said these cases impressed him in a somewhat different way from what they did Dr. Dercum, apparently. It seemed to him that the lack of menstruation is but a manifestation of that disharmonious development of which retention of the pituitary gland is itself an indication. The part of the paper that is of greatest interest to him is that which referred to the statements of some of the clinicians who saw that the patients had edema or that they were on the look out for it. It is quite possible that the pre-hypophysis throws into the economy a secretion similar to the secretion of the thyroid gland, and that one of the manifestations of this secretion is a constitutional condition—one might almost say a cachexia—not similar to it, but analogous to the condition that arises from hyperthyroidization. This condition might likewise account for the ventricular manifestations described in this case.

Dr. Cushing replied in regard to what Dr. Spiller had said concerning the occurrence of choked disc in intracranial hemorrhage. They had found that condition in almost all cases of intracranial hemorrhage.

The cases with loss of sexual power mentioned by Dr. Dercum seem to be quite common.

(*To be continued.*)

NEW YORK NEUROLOGICAL SOCIETY.

April 3, 1906.

The President, Dr. Joseph Fraenkel, in the Chair.

A Case of Cerebral Neoplasm.—Dr. William B. Noyes exhibited a skiagraph taken by Dr. Charles M. Cauldwell which showed a distinct shadow over the ponto-cerebellar region. The case was that of an Italian boy, eleven years old, who had been shown by Dr. Noyes at a meeting of the Society in 1905. There was no history of syphilis nor tuberculosis. The earliest manifestation of his trouble was pseudo-ptosis, first in the right eye, and then in the left. He complained of frequent headaches, located in the region of the right ear and the right frontal region, and vomited at times.